Division of TennCare

Health Care Innovation Initiative

Executive Summary

Colposcopy Episode

Corresponds with DBR and Configuration file V3.0

Updated: January 2, 2020

OVERVIEW OF A COLPOSCOPY EPISODE

The colposcopy episode revolves around patients who receive a colposcopy procedure. The trigger event is an office or outpatient colposcopy procedure. Specific related care – such as anesthesia, imaging and testing, medications, pathology, surgical and medical procedures – is included in the episode. The quarterback, also called the principal accountable provider or PAP, is the clinician or group performing the colposcopy. The colposcopy episode begins with the triggering procedure and ends 90 days after the triggering procedure.

CAPTURING SOURCES OF VALUE

Providers have multiple opportunities during a colposcopy episode to improve the quality and cost of care. Important sources of value include appropriate use of concurrent diagnostic or treatment procedures, such as biopsy, curettage, and excision. Other important sources of value include the appropriate use of medications during and after the procedure and appropriate referral to loop electrode excision procedure (LEEP) or conization care.

To learn more about the episode's design, please reference the Detailed Business Requirements (DBR) and Configuration File on our website at https://www.tn.gov/tenncare/health-care-innovation/episodes-of-care/searchable-episodes-table.html.

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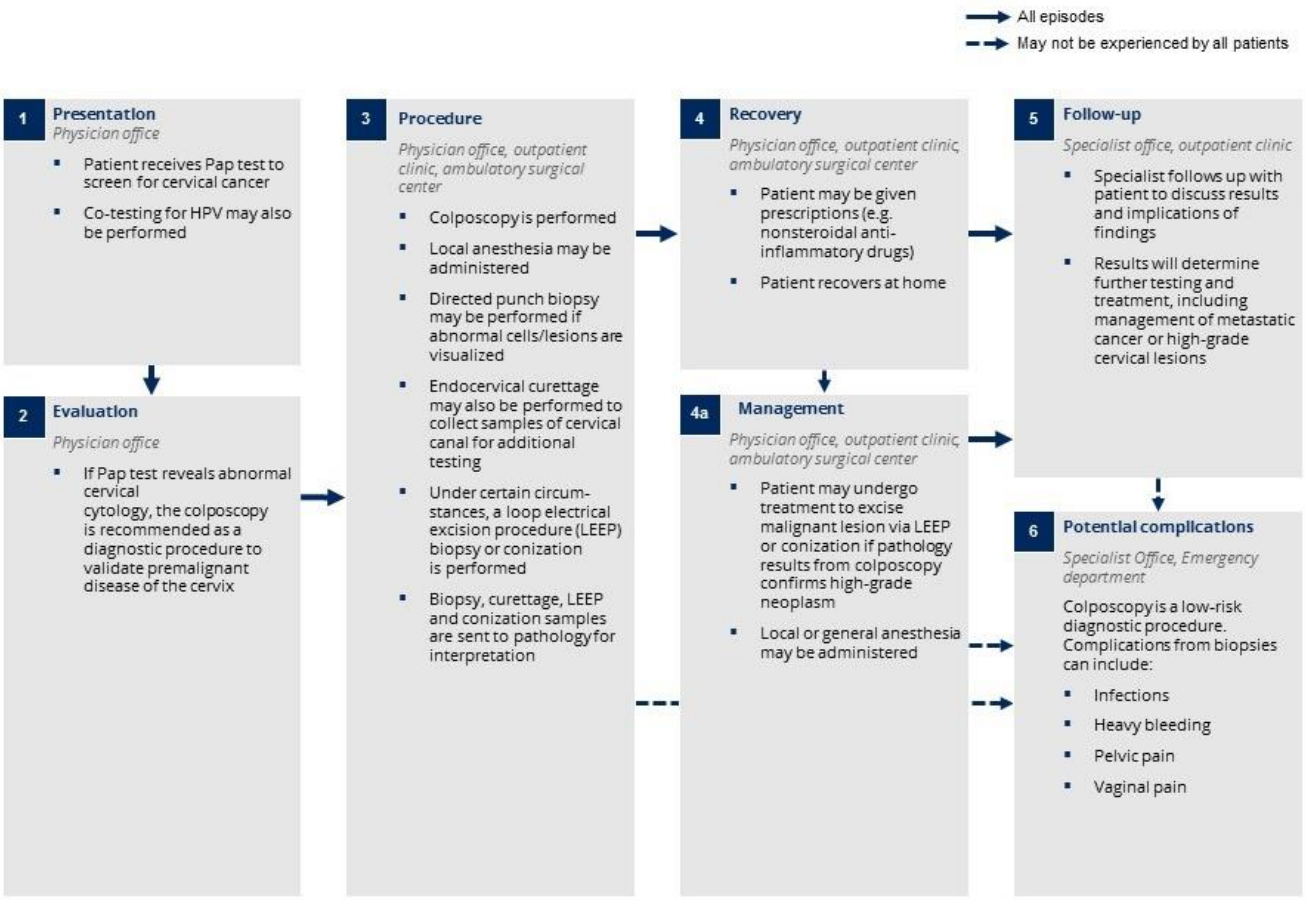
Illustrative Patient Journey



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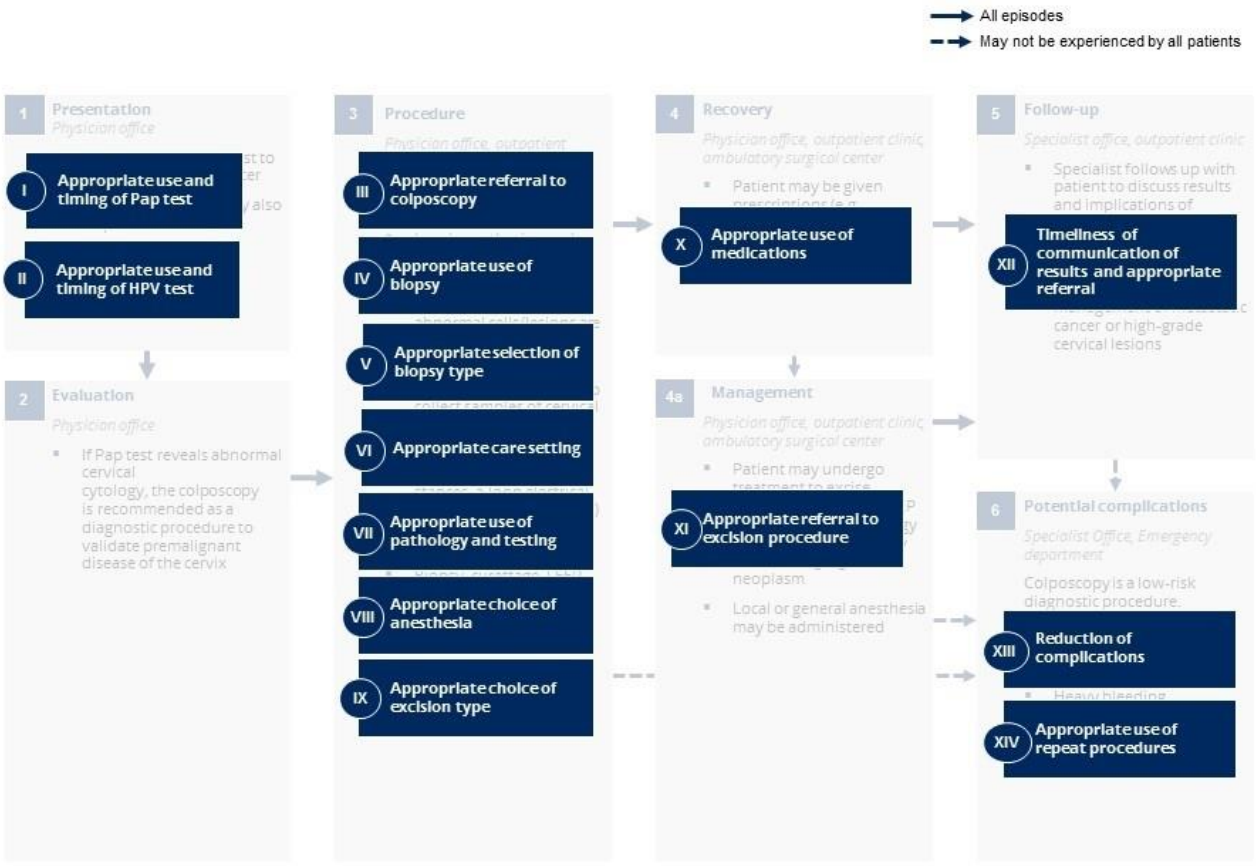
Potential Sources of Value



ASSIGNING ACCOUNTABILITY

The quarterback of the episode is the specific health care provider deemed to have the greatest accountability for the quality and cost of care for the patient. To state it differently, the quarterback is the provider who has the greatest ability to influence all of the health care delivered in a given episode. For the colposcopy episode, the quarterback is the clinician or group who performed the procedure. The contracting entity or tax identification number of the clinician or group performing the colposcopy will be used to identify the quarterback.

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MAKING FAIR COMPARISONS

The episode model is designed to be fair to providers and incentivize best practices without penalizing providers who care for sicker patients. As such, important aspects of the model are:

- Inclusion of only the cost of services and medications that are related to the colposcopy in calculation of episode spend.
- Exclusion of episodes when clinical circumstances create the likelihood that the case will deviate substantially from the typical care path or when claims data is likely to be incomplete.
- Risk adjusting episode spend to account for the cost of more complicated patients.

The colposcopy episode has no pre-trigger window. The trigger and post-trigger windows include care for specific diagnoses, specific anesthesia, specific imaging and testing, specific medications, specific pathology, and specific surgical and medical procedures.

Some exclusions apply to any type of episode, i.e., are not specific to a colposcopy. For example, an episode would be excluded if more than one payer was involved in a single episode of care, if the patient was not continuously insured by the payer during the duration of the episode, or if the patient had a discharge status of 'left against medical advice'. Examples of exclusion criteria specific to the colposcopy episode include patients who are pregnant or patients with cervical cancer. These patients have significantly different clinical courses that the episode does not attempt to risk adjust. Furthermore, there may be some factors with a low prevalence or significance that would make accurate risk adjustment difficult and may be used to exclude patients completely instead of adjusting their costs.

For the purposes of determining a quarterback's cost of each episode of care, the actual reimbursement for the episode will be adjusted to reflect risk factors captured in recent claims data in order to be fair to providers caring for more complicated patients. Examples of patient factors likely to lead to the risk adjustment of a colposcopy episode include asthma and chronic obstructive pulmonary disease, back and spine disorders, mood disorders, or cervical

intraepithelial neoplasia (CIN) 3. Over time, a payer may adjust risk factors based on new data.

MEASURING QUALITY

The episode reimbursement model is designed to reward providers who deliver cost effective care AND who meet certain quality thresholds. A quarterback must meet or exceed all established benchmarks for any quality metric tied to gain sharing in order to be eligible to receive monetary rewards from the episode model. Other quality metrics may be tracked and reported for quality improvement purposes but may not be tied directly to gain sharing.

The quality metrics linked to gain sharing for the colposcopy are:

- **LEEP utilization under 26 years old with no evidence of high grade dysplasia:** Percentage of valid episodes ages <26 and no evidence of high grade dysplasia with a LEEP or conization during the episode window (lower rate indicative of better performance)
- **LEEP utilization with low-grade dysplasia**: Percentage of valid episodes with a LEEP or conization during the episode window and a dysplasia diagnosis of CIN 1 or below (lower rate indicative of better performance)

The quality metrics that will be tracked and reported to providers but that are not tied to gain sharing are:

- **Cervical cancer screening**: Percentage of valid episodes with a cervical cancer screening within 90 days prior to the triggering colposcopy (higher rate indicative of better performance)
- **Diagnostic colposcopy**: Percentage of valid episodes with a diagnostic colposcopy during the post-trigger window (lower rate indicative of better performance)
- **LEEP utilization, trigger**: Percentage of valid episodes with a LEEP or conization during the trigger window (rate not indicative of performance)
- **LEEP utilization, episode**: Percentage of valid episodes with a LEEP or conization during the episode window (rate not indicative of performance)

- **Difference in average MED[1]/day**: Average difference in MED/day between opioid prescriptions during the episode window and for 1 to 60 days before the trigger window, across valid episodes (lower value indicative of better performance)
- **Average MED/day during pre-trigger opioid window**: Average MED/day for opioid prescriptions for 1 to 60 days before the trigger, across valid episodes (value not indicative of performance)
- **Average MED/day during post-trigger opioid window**: Average MED/day for opioid prescriptions for during the episode window, across valid episodes (value not indicative of performance)
- **Opioid and benzodiazepine prescriptions**: Percentage of valid episodes with both opioid and benzodiazepine prescriptions during the episode window (lower rate indicative of better performance)

It is important to note that quality metrics are calculated by each payer on a per quarterback basis across all of a quarterback's episodes covered by that payer. Failure to meet all quality benchmarks tied to gain sharing will render a quarterback ineligible for gain sharing with that payer for the performance period under review.

[1] MED: morphine equivalent dose